FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041871

Facility Name: Provena St Joseph Center

Address: 659 East Jefferson Street (Number) Freeport (City) 61032 (Zip Code)

County: Stephenson

Telephone Number: (815) 232-6181 **Fax #** (815) 232.6143

IDPA ID Number: 371127787011

Date of Initial License for Current Owners: 07/01/96

Type of Ownership:

- [X] VOLUNTARY,NON-PROFIT
  - [X] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

IRS Exemption Code 501 C3

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Michael R. Gordon

(Title) VP of Finance, CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,822	19,592	3,941	40,355	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,822	19,592	3,941	40,355	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.13%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/1996

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 120 and days of care provided 3,941

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	302,918	31,983	14,473	349,374		349,374		349,374			1
2	Food Purchase		166,569		166,569		166,569	(33,372)	133,197			2
3	Housekeeping	87,135	22,335	50	109,520		109,520		109,520			3
4	Laundry	106,645	20,187		126,832		126,832		126,832			4
5	Heat and Other Utilities			320,049	320,049		320,049	1,587	321,636			5
6	Maintenance	85,983	27,019	68,612	181,614		181,614	31,959	213,573			6
7	Other (specify):* **Pastoral Care/Dev.**	19,455	2,840	16,657	38,952		38,952	(18,422)	20,530			7
8	**TOTAL General Services**	602,136	270,933	419,841	1,292,910		1,292,910	(18,248)	1,274,662			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,909,648	143,602	43,687	2,096,937		2,096,937		2,096,937			10
10a	Therapy			166,140	166,140		166,140		166,140			10a
11	Activities	69,302	1,118	3,437	73,857		73,857	1,740	75,597			11
12	Social Services	55,080	23	1,263	56,366		56,366		56,366			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,034,030	144,743	226,527	2,405,300		2,405,300	1,740	2,407,040			16
	C. General Administration											
17	Administrative	197,548	15,536	664,800	877,884		877,884	(338,753)	539,131			17
18	Directors Fees											18
19	Professional Services			16,206	16,206		16,206	189,800	206,006			19
20	Dues, Fees, Subscriptions & Promotions			29,276	29,276		29,276	(8,584)	20,692			20
21	Clerical & General Office Expenses			295,743	295,743		295,743	(1,808)	293,935			21
22	Employee Benefits & Payroll Taxes			679,864	679,864		679,864	103,698	783,562			22
23	Inservice Training & Education			10,639	10,639		10,639	5,328	15,967			23
24	Travel and Seminar			8,113	8,113		8,113	5,950	14,063			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			90,428	90,428		90,428	6,392	96,820			26
27	Other (specify):* **Bad Debt**			31,121	31,121		31,121	(31,121)				27
28	**TOTAL General Administration**	197,548	15,536	1,826,190	2,039,274		2,039,274	(69,098)	1,970,176			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,833,714	431,212	2,472,558	5,737,484		5,737,484	(85,606)	5,651,878			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Provena St Joseph Center #0041871 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			194,990	194,990		194,990	65,994	260,984			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							182,793	182,793			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							15,963	15,963			34
35	Rent-Equipment & Vehicles			3,842	3,842		3,842	846	4,688			35
36	Other (specify):*											36
37	**TOTAL Ownership**			198,832	198,832		198,832	265,596	464,428			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			209,777	209,777		209,777		209,777			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			275,657	275,657		275,657		275,657			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,833,714	431,212	2,947,047	6,211,973		6,211,973	179,990	6,391,963			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(36,230)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,519	30		9
10	Interest and Other Investment Income	(2,084)	32		10
11	Discounts, Allowances, Rebates & Refunds	(14,421)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,121)	27		24
25	Fund Raising, Advertising and Promotional	(18,093)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (92,430)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	290,842		34
35	Other- Attach Schedule	(18,422)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 272,420		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 179,990		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Provena St Joseph Center

ID# 0041871

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development - Office Supplies	$ (1,725)	7	1
2	Development - Books, Subscriptions	(13)	7	2
3	Development - Other Supplies	(503)	7	3
4	Development - Advertising/Mktg	(338)	7	4
5	Development - Postage	(300)	7	5
6	Development - Activities	(40)	7	6
7	Development - Misc.	(15,503)	7	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(18,422)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(36,230)	2,858	0	0	0	0	0	0	0	0	0	(33,372)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,587	0	0	0	0	0	0	0	0	0	1,587	5
6	Maintenance	0	557	31,402	0	0	0	0	0	0	0	0	31,959	6
7	Other (specify):*	(18,422)	0	0	0	0	0	0	0	0	0	0	(18,422)	7
8	**TOTAL General Services**	(54,652)	5,002	31,402	0	0	0	0	0	0	0	0	(18,248)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,740	0	0	0	0	0	0	0	0	0	1,740	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	1,740	0	0	0	0	0	0	0	0	0	1,740	16
	C. General Administration													
17	Administrative	0	(320,469)	(18,284)	0	0	0	0	0	0	0	0	(338,753)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	31,915	157,885	0	0	0	0	0	0	0	0	189,800	19
20	Fees, Subscriptions & Promotions	(18,093)	9,509	0	0	0	0	0	0	0	0	0	(8,584)	20
21	Clerical & General Office Expenses	(14,421)	12,613	0	0	0	0	0	0	0	0	0	(1,808)	21
22	Employee Benefits & Payroll Taxes	0	51,132	52,566	0	0	0	0	0	0	0	0	103,698	22
23	Inservice Training & Education	0	5,328	0	0	0	0	0	0	0	0	0	5,328	23
24	Travel and Seminar	0	5,950	0	0	0	0	0	0	0	0	0	5,950	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	6,392	0	0	0	0	0	0	0	0	0	6,392	26
27	Other (specify):*	(31,121)	0	0	0	0	0	0	0	0	0	0	(31,121)	27
28	**TOTAL General Administration**	(63,635)	(197,630)	192,167	0	0	0	0	0	0	0	0	(69,098)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(118,287)	(190,888)	223,569	0	0	0	0	0	0	0	0	(85,606)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Provena St Joseph Center** **#** **0041871** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	9,519	0	56,475	0	0	0	0	0	0	0	0	65,994	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,084)	0	184,877	0	0	0	0	0	0	0	0	182,793	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	15,963	0	0	0	0	0	0	0	0	15,963	34
35	Rent-Equipment & Vehicles	0	0	846	0	0	0	0	0	0	0	0	846	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	7,435	0	258,161	0	0	0	0	0	0	0	0	265,596	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(110,852)	(190,888)	481,730	0	0	0	0	0	0	0	0	179,990	45

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Senior Services	100.00%	$ 2,858	$ 2,858	1
2	V	5	Utilities		Provena Senior Services	100.00%	1,587	1,587	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	557	557	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	1,740	1,740	4
5	V	17	Admin - Misc. Other	520,800	Provena Senior Services	100.00%	14,910	(505,890)	5
6	V	17	Administrative Salaries		Provena Senior Services	100.00%	185,421	185,421	6
7	V	19	Professional Services		Provena Senior Services	100.00%	31,915	31,915	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	9,509	9,509	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	12,613	12,613	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	51,132	51,132	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	5,328	5,328	11
12	V	24	Travel		Provena Senior Services	100.00%	5,950	5,950	12
13	V	26	Insurance		Provena Senior Services	100.00%	6,392	6,392	13
14	Total			$ 520,800			$ 329,912	$ * (190,888)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Provena Senior Services	100.00%	$ 3,032	$ 3,032	15
16	V	32	Interest		Provena Senior Services	100.00%	184,877	184,877	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	15,963	15,963	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	846	846	18
19	V	17	Admin Salaries	85,200	Provena Health Services	100.00%	56,024	(29,176)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	23,425	23,425	20
21	V	30	Depreciation		Provena Health Services	100.00%	53,443	53,443	21
22	V	19	Admin Consulting,Other		Provena Health Services	100.00%	157,885	157,885	22
23	V	17	Information Systems Salaries	58,800	Provena Health Services	100.00%	12,703	(46,097)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	5,312	5,312	24
25	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	5,666	5,666	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	34,965	34,965	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	14,620	14,620	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	22,024	22,024	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	9,209	9,209	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	25,736	25,736	30
31	V	39	Ancillary Services - Other	209,777	Provena Senior Services Pharmacy	100.00%	209,777		31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 353,777			$ 835,507	$ * 481,730	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	5,261,654	20	$ 28,878	$	520,800	$ 2,858	1
2	5	Utilities	Management Fee Income	5,261,654	20	16,037		520,800	1,587	2
3	6	Maintenance - Other	Management Fee Income	5,261,654	20	5,629		520,800	557	3
4	11	Activities-Special Events	Management Fee Income	5,261,654	20	17,583		520,800	1,740	4
5	17	Admin - Misc. Other	Management Fee Income	5,261,654	20	150,633		520,800	14,910	5
6	17	Administrative Salaries	Management Fee Income	5,261,654	20	1,873,311	1,873,311	520,800	185,421	6
7	19	Professional Services	Management Fee Income	5,261,654	20	322,442		520,800	31,915	7
8	20	Dues,Subscriptions	Management Fee Income	5,261,654	20	96,069		520,800	9,509	8
9	21	Clerical Supplies	Management Fee Income	5,261,654	20	127,431		520,800	12,613	9
10	22	Employee Benefits	Management Fee Income	5,261,654	20	516,585		520,800	51,132	10
11	23	Education/Conference	Management Fee Income	5,261,654	20	53,828		520,800	5,328	11
12	24	Travel	Management Fee Income	5,261,654	20	60,116		520,800	5,950	12
13	26	Insurance	Management Fee Income	5,261,654	20	64,582		520,800	6,392	13
14	30	Depreciation	Management Fee Income	5,261,654	20	30,629		520,800	3,032	14
15	32	Interest	Management Fee Income	5,261,654	20	1,867,812		520,800	184,877	15
16	34	Rent - Facility	Management Fee Income	5,261,654	20	161,270		520,800	15,963	16
17	35	Rent - Equipment	Management Fee Income	5,261,654	20	8,543		520,800	846	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,401,378	$ 1,873,311		$ 534,630	25

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfort, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,146,264	10	$ 753,738	$ 753,738	85,200	$ 56,024	1
2	22	Employee Benefits	Operating Expense	1,146,264	10	315,161		85,200	23,425	2
3	30	Depreciation	Operating Expense	1,146,264	10	719,013		85,200	53,443	3
4	19	Admin Consulting,Other	Operating Expense	1,146,264	10	2,124,158		85,200	157,885	4
5	17	Information Systems Salaries	Operating Expense	791,616	10	171,021	171,021	58,800	12,703	5
6	22	Information Systems Benefits	Operating Expense	791,616	10	71,509		58,800	5,312	6
7	6	Information Systems - Equip Mair	Operating Expense	791,616	10	76,287		58,800	5,666	7
8	17	Admin Salaries	Direct Cost	1,146,264	10	470,416	470,416	85,200	34,965	8
9	22	Employee Benefits	Direct Cost	1,146,264	10	196,696		85,200	14,620	9
10	17	Information Systems Salaries	Direct Cost	791,616	10	296,512	296,512	58,800	22,024	10
11	22	Information Systems Benefits	Direct Cost	791,616	10	123,981		58,800	9,209	11
12	6	Information Systems - Equip Mair	Direct Cost	791,616	10	346,486		58,800	25,736	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,664,978	$ 1,691,687		$ 421,012	25

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 209,777	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 209,777	25

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Provena Senior Services										182,793	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 182,793	14
15	TOTALS (line 9+line14)						$	$			$ 182,793	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000		**8**
	2001		**9**
	2002		**10**
	2003		**11**
	2004		**12**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	**13**
14	PLUS APPEAL COST FROM LINE 5	$	**14**
15	LESS REFUND FROM LINE 6	$	**15**
16	AMOUNT TO USE FOR RATE CALCULATION	$	**16**

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena St Joseph Center COUNTY Stephenson

FACILITY IDPH LICENSE NUMBER 0041871

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,080 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		1996	$ 1,400,000	1
2					2
3	TOTALS			$ 1,400,000	3

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1996	1994	$ 2,500,000	$ 62,500	40	$ 62,500	$	$ 593,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1997	33,624	1,486	8	1,486		25,718	9
10	Various			1998	15,953	372	6	372		15,023	10
11	Various			1999	80,775	5,643	11	5,643		38,757	11
12	Various			2000	21,185	2,143	6	2,143		18,493	12
13	Various			2001	28,726	3,855	7	3,855		20,043	13
14											14
15	DESC: DRYER			2002	3,295	659	5	659		2,307	15
16	DESC: ADULT ALL-ADJ STAND-IN TBL			2002	867	58	15	58		202	16
17	DESC: 200 AMP			2002	11,750	1,175	10	1,175		4,113	17
18	DESC: PLUMBING SUPPLIES FOR NEW BATHROOM			2002	425	28	15	28		85	18
19	DESC: BATHROOM REMODELING			2002	2,366	158	15	158		473	19
20	DESC: CARPETING FOR BEDROOD AND DINING ROO			2002	672	134	5	134		470	20
21	DESC: DRAPES			2002	15,414	3,083	5	3,083		10,790	21
22	DESC: ROOF REPAIR			2002	1,800	180	10	180		540	22
23	DESC: REPLACEMENT OF BRICKS ON HANDICAP RA			2002	2,055	103	20	103		360	23
24	DESC: KITCHEN CABINETS AND WALL BOARD			2002	5,260	351	15	351		1,227	24
25	DESC: CABINETS AND COUNTER TOPS			2002	1,105	74	15	74		258	25
26	DESC: PAINT & MISC SUPPLIES FOR REMODELING			2002	800	160	5	160		560	26
27	DESC: CARPETING ADULT DAY CARE OFFICE			2002	477	95	5	95		334	27
28	DESC: REPLACEMENT OF DAMAGED STREAM PIPES			2002	2,497	166	15	166		499	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DESC: INSTALLATION OF AWNING	2003	$ 2,950	$ 295	10	$ 295	$	$ 738	37
38	DESC: INSTALLATION OF ELECTRIC BASEBOARD H	2003	751	75	10	75		188	38
39	DESC: DUCTLESS SPLIT SYSTEM FOR O'NEILL HA	2003	11,700	780	15	780		1,950	39
40	DESC: DURO LASST ROOFING SYSTEM	2003			10				40
41	DESC: 4 FT IRON FENCE	2003	2,526	168	15	168		421	41
42	DESC: DURO-LAST ROOFING SYSTEM	2003	21,167	2,117	10	2,117		5,292	42
43	DESC: SAWCUTTING OF CONCRETE ROOFING	2003	300	60	5	60		150	43
44	DESC: VINYL POCKET REPLACEMENT	2003	2,343	469	5	469		1,172	44
45	DESC: A/C COMPRESSOR	2003	3,583	299	12	299		746	45
46	DESC: TRINITY HOUSE ROOF	2003	7,125	713	10	713		1,781	46
47	DESC: VINYL WINDOW REPLACEMENTS	2003	2,943	420	7	420		1,051	47
48	DESC: BOILER REPLACEMENT	2003	2,227	111	20	111		223	48
49	DESC: REBUILD HIP & RAFTERS ON FRONT PORCH	2003	5,598	560	10	560		1,399	49
50	DESC: REWIRE 2ND FLOOR OF O'NIELL HALL	2003	12,500	1,250	10	1,250		3,125	50
51	DESC: UPGRADE SERVICE FOR VILLA HOME	2003	3,250	325	10	325		813	51
52	DESC: ROOF REMOVAL	2003	4,000	400	10	400		1,000	52
53	DESC: CLF BATH AND SHOWER UPGRADE	2003	1,414	141	10	141		283	53
54									54
55	DESC: BOILER REPAIR	2004	1,766	177	10	177		265	55
56	DESC: BOILER REPAIR	2004	1,355	90	15	90		136	56
57	DESC: BOILER REPAIR	2004	1,015	102	10	102		152	57
58	DESC: PLASTER WORK IN LARGE CHAPEL	2004	5,150	515	10	515		773	58
59	DESC: PAINTING OF CHAPEL	2004	9,500	1,900	5	1,900		2,850	59
60	DESC: HEAT EXCHANGE FOR MAIN BOILER	2004	4,983	498	10	498		747	60
61	DESC: TELEPHONE SYSTEM	2004	5,303	530	10	530		795	61
62	DESC: CARPTET AND LABOR	2004	7,030	1,406	5	1,406		2,109	62
63	DESC: ADD SPRINKLER TO STORAGE ROOM	2004	1,680	112	15	112		168	63
64	DESC: TOWER ROOF REPAIRS	2004	795	80	10	80		80	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,851,998	$ 96,015		$ 96,015	$	$ 762,407	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,851,998	$ 96,015		$ 96,015	$	$ 762,407	1
2	DESC: AUTOMATIC DOOR EQUIPMENT	2005	6,284	314	10	628	314	628	2
3	DESC: REPLACE FIREBOARD FOR ADC/CLF	2005	21,223	1,061	10	2,122	1,061	2,122	3
4	DESC: REPAIR UNDERGROUND STEAM LEAK	2005	6,710	336	10	671	336	671	4
5	DESC: SEWER LINE	2005	18,420	461	20	921	461	921	5
6	DESC: REMOVAL OF WALL IN TV LOUNGE - CLF	2005	965	48	10	97	48	97	6
7	DESC: CARPETING	2005	563	56	5	113	56	113	7
8	DESC: 51" TOSHIBA HDTV MONITOR	2005	1,499	150	5	300	150	300	8
9	DESC: ASPHALT - CLF PROGRAM	2005	2,364	148	8	295	148	295	9
10	DESC: REPLACE FIREBOARD FOR ADC/CLF	2005	697	35	10	70	35	70	10
11	DESC: BOILER AT ONEILL HALL/REBUILD STEAM	2005	30,950	774	20	1,548	774	1,548	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,941,674	$ 99,397		$ 102,780	$ 3,382	$ 769,171	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 700,104	$ 80,887	$ 80,887	$	9	$ 489,394	71
72	Current Year Purchases	106,655	6,137	12,274	6,137	10	12,274	72
73	Fully Depreciated Assets	73,500					73,500	73
74	Home office allocation		56,475	56,475				74
75	TOTALS	$ 880,259	$ 143,499	$ 149,636	$ 6,137		$ 575,168	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transport	2001 Mercury Sable	2001	$ 23,123	$	$	$	3	$ 23,123	76
77		1997 Dodge 2500	1997	24,090				5	24,090	77
78		Ford Turtle Top Van	2004	34,275	8,569	8,569		4	12,853	78
79										79
80	TOTALS			$ 81,488	$ 8,569	$ 8,569	$		$ 60,066	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,303,420	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 251,465	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 260,984	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,519	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,404,405	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	home office allocation				15,963			5
6								6
7	TOTAL				$ 15,963 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO
16. Rental Amount for movable equipment: $ 28,725 Description: Nursig - $24,036.94, Admin - $3,841.89, Home office - $846
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	$	1,431	$ 74,680	$	1,431	$ 74,680	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		144	7,502		144	7,502	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		1,608	83,958		1,608	83,958	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				209,777		209,777	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	3,183	$ 166,140	$ 209,777	3,183	$ 375,917	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Provena St Joseph Center # 0041871 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,947,364	$	1
2	Cash-Patient Deposits	102,762		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,022,174		3
4	Supply Inventory (priced at)	562,029		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,455		6
7	Other Prepaid Expenses	234,588		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 19,922,372	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,323,187		12
13	Land	6,872,845		13
14	Buildings, at Historical Cost	79,429,531		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,136,519		16
17	Accumulated Depreciation (book methods)	(44,514,067)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	133,848		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 65,381,863	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 85,304,235	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,028,501	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,196,854		28
29	Short-Term Notes Payable	35,066		29
30	Accrued Salaries Payable	2,281,363		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,968		31
32	Accrued Real Estate Taxes(Sch.IX-B)	222,071		32
33	Accrued Interest Payable	26,274		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	542,408		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,385,505	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,329,784		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	219,687		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	616,044		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,165,515	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,551,020	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,753,215	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 85,304,235	$	48

***(See instructions.)**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 72,625,309	1	
2	Restatements (describe):		2	
3	**FAS47 Change in accounting principal**	(271,871)	3	
4	**Adj. To Reconcile Consolidated Equity and Consolidated**	2,445,136	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 74,798,574	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(75,006)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock	(40,261)	9	
10	Stock Options Exercised		10	
11	Contributions and Grants	240,328	11	
12	Expenditures for Specific Purposes	(170,420)	12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (45,359)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 74,753,215	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,213,236	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,213,236	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	479,151	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 479,151	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	36,230	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	10,180	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	384	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 46,794	23
	D. Non-Operating Revenue		
24	Contributions	276,198	24
25	Interest and Other Investment Income***	2,084	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 278,282	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	108,433	28
28a	Misc. Income	11,071	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 119,504	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,136,967	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,292,910	31
32	Health Care	2,405,300	32
33	General Administration	2,039,274	33
	B. Capital Expense		
34	Ownership	198,832	34
	C. Ancillary Expense		
35	Special Cost Centers	209,777	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,211,973	40
41	**Income before Income Taxes (line 30 minus line 40)****	(75,006)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (75,006)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,848	2,080	$ 62,860	$ 30.22	1
2	Assistant Director of Nursing	1,596	1,780	40,224	22.60	2
3	Registered Nurses	10,669	11,366	252,714	22.23	3
4	Licensed Practical Nurses	32,462	34,371	635,897	18.50	4
5	CNAs & Orderlies	79,535	84,737	855,353	10.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,312	5,645	62,600	11.09	8
9	Activity Director	1,896	2,080	27,383	13.16	9
10	Activity Assistants	4,299	4,639	41,919	9.04	10
11	Social Service Workers	3,421	3,809	55,080	14.46	11
12	Dietician	1,860	2,080	36,650	17.62	12
13	Food Service Supervisor	2,234	2,429	28,231	11.62	13
14	Head Cook	6,485	7,092	64,149	9.05	14
15	Cook Helpers/Assistants	21,295	22,804	173,888	7.63	15
16	Dishwashers					16
17	Maintenance Workers	6,582	7,045	85,983	12.20	17
18	Housekeepers	10,254	11,170	87,135	7.80	18
19	Laundry	11,322	12,472	106,645	8.55	19
20	Administrator	1,824	2,080	86,704	41.68	20
21	Assistant Administrator					21
22	Other Administrative	2,573	2,779	35,375	12.73	22
23	Office Manager					23
24	Clerical	6,043	6,658	75,469	11.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral Care	1,660	1,940	19,455	10.03	33
34	TOTAL (lines 1 - 33)	213,170	229,056	$ 2,833,714 *	$ 12.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	273	$ 14,183	1,3	35
36	Medical Director	$1000/mth	12,000	9,3	36
37	Medical Records Consultant	20	1,452	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	3	149	11,3	44
45	Social Service Consultant	28	1,642	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	324	$ 29,426		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	96	3,188	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	96	$ 3,188		53

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Theresa Parsek	Administrator	0	$ 86,704
Adminstrative Staff	Bookkeeper	0	27,276
Adminstrative Staff	Admissions	0	8,099
Adminstrative Staff	Receptionist	0	38,674
Adminstrative Staff	Admini Asst	0	36,795
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 197,548

B. Administrative - Other

Description	Amount
Corp Service Fee	$ 85,200
Corp Service IS Fee	58,800
Mgmt Fee	255,600
Mgmt Fee Interest	265,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 664,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 6,351
Survey & Analytical Tools	Various	5,147
Shredding	Various	70
Living Design	Various	348
Background Checks	Various	1,000
Outsourced Services	Various	3,290
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 16,206

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,400
Unemployment Compensation Insurance	24,368
FICA Taxes	200,090
Employee Health Insurance	290,338
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	12,787
Pension	98,899
Employee Recognition	1,846
Executive Benefits	5,601
Employee Screenings	7,535
Home Office Allocation	103,698
TOTAL (agree to Schedule V, line 22, col.8)	$ 783,562

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 52)	
Employee Recruitment	2,687
Dues & Subscriptions	7,370
Advertising & Public Relations	19,219
Home Office Allocation	9,509
Less: Public Relations Expense	( )
Non-allowable advertising	(18,093)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,692

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,113
Seminar Expense	
Home Office Allocation	5,950
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,063

**See instructions.

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Provena St Joseph Center # 0041871 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **5135 Life Service Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **120**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,120** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **65,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **36,230**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.